## WC-14a REQUEST TO CHANGE INFORMATION ON A PREVIOUSLY FILED FORM WC-14

## **GEORGIA STATE BOARD OF WORKERS' COMPENSATION**

## REQUEST TO CHANGE INFORMATION ON A PREVIOUSLY FILED FORM WC-14

**Instructions:** The purpose of this form is to change mistakes concerning certain information (Employee Name, Social Security Number, Date of Injury, or County of Injury) on a previously filed Form WC-14. If you want to change mistakes with information previously furnished on a Form WC-14, then indicate the change on this form and file it with the Board. Complete a new Form WC-14 to add or change any information pertaining to the employer, insurer, servicing agent, part of body injured, to add date of injury, hearing issue, or mediation issue. This form shall not be used to change an address of record, add additional parties, or additional dates of injury.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
A. CHANGED INFORMATION The information provided on the Form WC-14 dated					
	Change From		Ch	ange To	
☐ Employee Name				5	
☐ Social Security Number					
☐ Date of Injury					
☐ County of Injury					
Reasons:					
B. CERTIFICATION					
□ I certify that I have today sent a copy of this form to all parties in this claim and to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299					
Print name here		Address			
Signature					
E-mail		,			
Phone Number		Date			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).